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## THE DUTIES AND RESPONSIBILITIES OF THE CIVIL SURGEON WHEN CALLED TO ACTIVE MILITARY SERVICE*

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IT has always been the custom of the American Surgical Association to allow the president a large measure of latitude in selecting the subject of his inaugural address; and while in the majority of instances the subjects presented have been strictly professional, in that they have dealt with some live surgical problem, on not a few occasions the topics chosen have been of historic or biographic interest, or have presented thoughts on medical education, professional ethics, public health, or military preparedness.

That the interest of the surgical profession, here and elsewhere, has been acutely centred, during the past few years, upon the various military phases of our art, is evidenced by the large number of communications presented at our last meeting which dealt with the treatment of battle casualties, and with their associated infections; or the new and improved methods employed in the care of those who had been injured by the novel and cruelly destructive agencies of modern warfare, which by their diabolical ingenuity, have far outclassed in their mutilating effects anything which the world has ever known; and if it were not for the fact that in our present session a part of our program is made up of papers dealing with these same topics, I feel that I might have yielded to the strong impulse to present to you on this occasion some personal observations and experiences in front area work.

I have, however, elected to speak this morning upon two matters not strictly germane to either the scientific or practical aspects of our professional work, but which I venture to hope may be of interest. The first is a report on the activities of the Fellows of this Association in war work, and the other the duties and responsibilities of the civil practitioner in time of war, or perhaps, to state it more definitely, the relationship between the Army Medical Corps and the trained civil surgeon when called to active military service.

When we consider that our Association embraces in its membership the great majority of the recognized leaders of surgery in America, that owing to the conditions of fellowship over 90 per cent. of its active members are well above the military age, and were under no moral obligation

* President's Address before the American Surgical Association, May 3, 1920.

to enter the Government service, it is a matter of genuine pride and satisfaction to know that over 85 per cent. of our Fellows promptly volunteered and gave generously of their time and effort to the cause. I know of no other body of men of equal standing in the community who gave so much and at a greater sacrifice of personal interests.

It is fitting, therefore, that some record of their activities be preserved and made a part of our Association Archives, not only to record the historic facts, but to furnish an example to those who may follow, in the event of another and similar national emergency.

I have, therefore, attempted to collect all available data as to the service rendered by members of this Association, and will give you a brief summary of the result.

The total number of Fellows, active and senior, who offered their services to the Government or engaged in actual war work was 154, the average age of these was fifty-six and one-half years. It is worthy of note that of the 33 senior Fellows, 25 volunteered or engaged in active service, the average age of this group being seventy.

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| Number holding commissions in the U. S. Army, including two contract surgeons.. | 96 |
| Number holding commissions in the British Army | 4 |
| Number holding commissions in the Canadian Army | 6 |
| Number holding commissions in the French Army | 1 |
| Members of the Reserve Corps, who volunteered but were not called to active duty or were rejected on account of age or physical disability | 6 |
| Volunteer surgeons serving with the British Army previous to 1917 | 5 |
| Volunteer surgeons serving with the French Army previous to 1917 | 13 |
| Commissioned officers in the U. S. Navy | 9 |
| Fellows serving in the Red Cross Society | 13 |
| Fellows serving in the Medical Advisory Committee of the Council of National Defense | 9 |
| Enrolled in the Volunteer Medical Service Corps | 11 |
| Serving in local military or examining boards, State organizations or detailed to give instruction in military surgery | 36 |

Of the 107 who held commissions in our own or one of the Allied armies, there were:

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| Brigadier-generals | 1 |
| Colonels | 25 |
| Lieutenant-colonels | 37 |
| Majors | 31 |
| Captains | 7 |
| First lieutenants | 4 |

In two instances the rank was not mentioned.

Of these, 57 served in France with the A. E. F., 48 in the United States, 11 in the French or British armies.

As a number of officers served at different times in two or more of the Allied armies, and in different organizations in our own army, the totals in this and the following groups obviously will not correspond to the exact number of commissioned officers.

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| Number serving in base or general hospitals | 55 |
| Number serving in evacuation hospitals or casualty clearing stations | 12 |
| Number serving in mobile hospitals | 3 |
| Number serving in camp hospitals | 6 |
| Number serving as heads of surgical teams | 19 |
| Number serving as consultants | 26 |
| Number serving at Headquarters at Washington | 8 |
| Number serving at Headquarters, A. E. F. | 2 |
| American delegates to Interallied Surgical Conferences in Paris | 6 |
| Fellows receiving one or more promotions | 77 |
| Fellows receiving decorations | 22 |
| Fellows receiving citations | 10 |
| Fellows mentioned in dispatches | 4 |
| Fellows serving in front area during one or more of the great battles | 47 |

This is but a brief and incomplete statement of the actual service rendered by our members, and is introduced here, merely to give a general idea of the important and responsible positions they held during the World War. I have prepared a fuller record of the services rendered by each of the Fellows, which will be appended to this address and published in the transactions.

Let us now consider my second topic, *The duties and responsibilities of the trained civil surgeon when called to active military service.*

That he has a definite responsibility can not be questioned when we consider that in time of war or active mobilization, the Medical Corps of the Army is of necessity greatly augmented by the enlistment of men from the reserve corps and from civil practice. To illustrate the extent of this augmentation, allow me to call attention to the fact that at the time of our declaration of war, the Medical Corps of our Army consisted of less than 500 medical officers. At the time of the armistice the number of commissioned medical officers was considerably over 30,000, which indicates that at that time more than 59/60, or 98.3 per cent., of the medical service of the Army was rendered by civilian practitioners, including surgeons, internists, sanitary experts, laboratory workers, and other specialists.

The chief function of the Medical Corps of an army is to render the best possible sanitary service to the troops, to keep them in the best physical condition, and to provide individual care and skilled professional attention for the sick and injured.

During peace this is not difficult, the number of sick and injured is small, the skill and experience of the officers are well known, and they easily can be assigned to duties which they are qualified to assume. In time of war or active mobilization, however, the problem is far more difficult, for it necessitates a complete reorganization of the corps, the assimilation of thousands of new men who are ignorant of army routine, and whose professional qualifications are to a large extent unknown.

When we consider the magnitude of the problem and the difficulties under which the Surgeon General labored during our recent mobilization, the marvel is that so much in the way of efficient organization was accomplished.

Laying aside for the moment the activities of the medical, sanitary, laboratory, and special departments, what was the chief surgical problem to be solved? I take it you will all agree with me that it was to render prompt and skilled surgical care to the man wounded in battle. The man who has the courage, patriotism, and determination to go into battle and give every ounce of energy and strength which he possesses to defeat the enemy, who cheerfully faces death and the chance of mutilating and disabling injury, is certainly entitled, when wounded, to the best surgical skill which his Government is able to provide. If he receives anything less than this, he is not being treated fairly, or, to use a commonplace expression, he is not getting a square deal.

How best can this be accomplished? To what extent was this accomplished in our own army during its participation in the great war? In answering the first question, I believe that one of the most important factors is to avoid misfits. By that I mean men who are assigned to duties they are not qualified to fulfill, or retained in such positions after their unfitness has been demonstrated. To obtain the best results only men of adequate surgical training and of large experience should be selected as operating surgeons in advanced hospitals where the wounded receive their first surgical treatment; and the work of these men should under no circumstances be hampered or interfered with by men of higher rank, but without skill, training, or experience in modern surgical procedures. Likewise in the base hospitals to which the wounded are quickly transferred from the front area, there should be a sufficient number of trained surgeons to oversee and direct the work of a larger number of junior officers, younger men, who have had at least some preliminary training in modern surgical technic.

That this ideal arrangement has not generally been carried out in the past will be evident to any one who will take pains to read the medical and surgical histories of any of the great wars of modern times. In the majority of instances these failures have been due, not to indifference on the part of a Government to the fate of its wounded soldiers, but to misfits in the professional personnel; expert surgeons who are assigned to purely executive duties, medical men who are assigned to responsible surgical posts, oculists, aurists, dermatologists, and X-ray operators who are obliged to work in medical or surgical wards, or in some specialty not their own, when their skill is urgently needed elsewhere; men well trained in laboratory methods but without experience in clinical work, obliged to give their entire attention to clinical problems.

All of these misfits I have personally observed in innumerable instances, have watched their bungling unproductive work, and have listened to a recital of their many efforts made through various channels to be given work which they felt themselves competent to carry out. I am not now speaking alone of our army, but of experience gathered while serving with the French or British forces; and I think it only fair to state

that, while numerous examples could be pointed out of such misfits in our own organization, my observations lead me to believe that there were fewer such instances in the A. E. F. than in the other Allied forces, and that it was far easier with us to effect satisfactory transfers, largely through the cordial relations which existed between our Chief Surgeon and the commanding officers of our sanitary groups.

One of the causes of this difficulty in the past has been due to the fact that ranking officials in the administrative bureaus, while perhaps possessing expert ability in executive matters, fail to recognize how highly specialized medicine has become during the past half century, to realize that the battle casualties of modern warfare present, in perhaps the majority of instances, the gravest of surgical problems, or to appreciate how utterly futile it is to expect these problems to be successfully met by men without or with but limited training or experience. As one British officer stated, "The men at Headquarters feel that every man possessing a medical diploma is capable of any and all kinds of professional work."

Another and perhaps the chief cause of misfits is the appointment of men to positions of grave professional responsibility on account of rank or previous service rather than professional qualifications. But the question is asked, How could this be otherwise without demoralizing the morale of the corps? The Army is an organization into which men enlist for life. They begin at the bottom and gradually work their way to the higher ranks by years of painstaking conscientious work, and when a man of mature age, after fifteen or twenty years of faithful service, reaches the rank of major, lieutenant-colonel, or colonel, is he not qualified to accept grave responsibility, and in the event of war, is it fair that he should be cast aside and replaced by a civilian who has never served in the Regular Army, and knows nothing of military routine?

Let us meet the issue squarely, and consider it from every angle, bearing in mind the paramount duty of the Government, which is to render to the wounded soldier the best possible surgical skill.

In the Regular Army the medical officer at the time of his enlistment is a highly qualified man, but with limited experience. During the first eight or ten years of his service, he is assigned to one or several military posts, where he has the care of a limited number of physically fit men, and the families of the officers. Between these assignments he may be stationed at a military hospital where he may have purely administrative duties, or may serve in medical or surgical wards. At other times he may have bureau work at Washington or at some divisional headquarters. As he advances in rank, he is given more responsible duties of an administrative character with a progressive diminution in actual professional work. As one major expressed it to the writer, "I have been seventeen years in the service. During my first six years my work was largely professional, during the next four or five years it was about equally

divided between professional and administrative duties; and for the past seven years I have had practically no professional responsibility."

Certainly the army in peace time is not an ideal school for the training of surgeons, and while there are, of course, notable exceptions, of men who have had long periods of service in hospitals on account of special aptitude for medical, surgical, or special work, the opportunities for intensive surgical training are few, and the majority of army surgeons who have served perhaps fifteen or more years, and have reached the rank of major or lieutenant-colonel, while they may be expert administrative officials, can not be regarded as highly qualified modern surgeons. Such an experience can not qualify even the most gifted man to meet the emergencies or assume the grave responsibilities of treating battle casualties.

With the recent civilian graduate who has chosen surgery as his special life work, it is entirely different. From the time he leaves the medical school his energy is directed in a single channel. He passes through the positions of surgical interne, house surgeon, or resident surgeon, outpatient surgeon, assistant surgeon to the wards, associate or junior surgeon; and at the age when our military surgeon reaches the rank of major or colonel, the civilian practitioner if capable and industrious has reached the goal of his ambition, is an attending surgeon to some hospital, a position gained by fifteen or twenty years of continuous intensive surgical training.

If in the necessary reorganization of the army medical corps in time of war, the general policy were followed of selecting highly qualified civilian surgeons, but without army experience, to positions of purely professional responsibility, where a knowledge of army administrative methods is not essential; and of the highly qualified members of the regular corps to positions of high administrative command, where their knowledge and experience are most needed, it would provide promotion and dignified positions for all the capable ranking men of the service, and would in no way tend to demoralize the morale of the department. It would also prevent in a large measure the misfits to which I have alluded, and would be the greatest factor in providing for the wounded soldier the highest type of surgical skill. This was the general policy in our army during the recent war; but with a less enlightened and broad-minded Surgeon General it might not be the policy in a future war. Moreover, the line was never definitely drawn between administrative and professional control, and most of us who served in France saw examples of men of high rank holding executive positions, issuing orders which if carried out to the letter would have sadly interfered with the orderly carrying on of modern surgical procedures.

This brings me to the second factor in accomplishing the highest degree of professional service to the wounded man; and that is the plan of dual control in all hospitals and all organizations in which the medical department has important activities. I realize that the term dual control

of any military formation will be said to be a blow at the very foundation of military discipline. Yet I venture to approve the plan for the reason that I believe it to be fundamentally sound, that it was first suggested and put into operation by our own Surgeon General, and also for the reason that I think it can be shown that by a reasonable interpretation it will not affect or interfere with military discipline in the slightest degree.

It will be recalled that long before we entered the war the Surgeon General authorized the organization of fifty Red Cross Base Hospitals, with the understanding that in case of war they would be taken over by the War Department and made an integral part of the army. The plan of organization was to supply for each a commanding officer appointed from the Medical Corps of the Regular Army, who would have complete administrative and disciplinary control of the unit; and a director who would be responsible for the actual care of the patients. By this plan these hospitals were placed on the same basis as our own best civil hospitals in which the Board of Trustees or administrative department is entirely separate from the professional, and in no way interferes with or attempts to dictate the scientific activities of the professional staff; but at all times is in absolute control, as they have the power of appointment and removal.

The success of the plan was, I think, generally admitted. In the unit to which I was attached and in a number of others in which there was a reasonable coöperation between the commanding officer and director, there was not the slightest friction, and no question of authority was ever raised; the director recognized that the commanding officer was his superior officer, and the commanding officer recognized the professional responsibilities of the director and never interfered with the clinical work of the unit.

In the late autumn of 1917 orders were sent from Washington to the A. E. F. to organize a group of professional consultants, to take over the responsibility of the care of patients in the various divisions as they became ready for active duty. Without going into detail in regard to the organization of this group, with which you doubtless are all familiar, I may briefly state that there was a chief consultant in surgery, a chief consultant in medicine, and a chief consultant in the laboratory specialties. Under each of these departments there were a number of subdivisions, those in surgery being: General surgery, orthopedics, urology, otology and laryngology, ophthalmology, facio-maxillary surgery, neurological surgery, and experimental surgery.

Special divisional consultants were first appointed in general surgery, orthopedic surgery, and urology. Later consultants in medicine, neurology, and some of the other specialties were appointed to divisional, corps, and army headquarters. At a still later period, surgical consultants were sent to a number of the large base hospital centres, where they would direct and supervise the professional work in the various hospital units.

Shortly after the creation of the Consulting Board, the Chief Surgeon of the A. E. F. authorized the chief consultant in surgery to organize surgical teams for active service at the front, relying upon his judgment in the selection of the officers to head each team. More than one hundred such teams, representing the best surgical talent in the overseas army, were organized and sent to the evacuation and advanced hospitals in the three or four great battles in the summer and autumn of 1918. During this active period the chief consultant arranged frequent conferences at which a number of the front area divisional or corps consultants took part, and at these meetings general rules regarding the surgical care and operative treatment of the various types of battle casualties were freely discussed and adopted, and instructions issued to all consultants to be transmitted to the heads of the surgical teams. These instructions in general conformed with the suggestions issued by the Inter-Allied Surgical Conference, modified to some extent by the experience of our own men. While few of our operating surgeons heading surgical teams had had any experience in the treatment of battle casualties, they were nearly all men of experience, with adequate surgical training, and in not a few instances had had opportunities to observe the best type of military surgical procedure in some of the best French, English, and Belgian hospitals, as well as in our own Evacuation Hospitals Nos. 1 and 2, which were organized early, in quiet sectors, and in which some of our most experienced men were operating and giving instruction in the technic of modern military surgery. This and the fact that nearly all of our consultants in the front area had had previous experience in the British, French, or Belgian armies, made it possible for our advanced hospitals to render such excellent service during the periods of great activity.

While I would not have you believe that this advanced service in any way approached perfection, I think I can truthfully say that, taken as a whole, it was better than I had previously observed in any sector of the same size during a period of active military operations. When failure or disaster occurred, it was not the result of lack of skillful operative measures, but was rather due to overcrowding, delayed transportation and absence of forethought in providing adequate hospital accommodations, teams, nurses, and supplies. In other words, it was due to administrative rather than professional errors.

From this brief statement regarding the general plan of dual control, I feel that you will all agree that it represented a wise and honest attempt on the part of our Surgeon General to improve the quality of the service rendered to our wounded men. That it was not more satisfactory in its operation was due to a number of circumstances.

In the first place the plan should have been carefully considered and its organization thoroughly effected before we entered the war.

Specific regulations should have been adopted defining the duties of

the administrative and professional chiefs, so that there should be no conflict of authority.

Copies of these regulations should have been sent to all commanding officers and to chief divisional, corps, and army surgeons, well in advance of assigning consultants to duty.

The official orders to consultants should have been uniform, explicit, and delivered at the time of appointment.

Had this been done, the status of the consultant would have been established. As it was, the arrival of the consultant at divisional headquarters was often the first intimation the chief divisional surgeon had that such a position had been created; and if, as frequently happened, the consultant's orders were not explicit, his presence was resented and looked upon as an attempt to destroy the prestige and undermine the authority of the divisional chief. In a few instances this resulted in open hostility and complete lack of coöperation, rendering the consultant's position extremely trying, and greatly interfering with his usefulness.

Lack of uniformity or great delay in issuing orders was a frequent source of misunderstanding. On more than one occasion I was sent to various parts of the line without any written orders. At other times my orders would read, "Will proceed to this or that headquarters and report to the divisional or corps surgeon." On other occasions my orders would be explicit and state, "Will proceed to Division ——, will supervise and direct the surgical work in all divisional hospitals, and all evacuation hospitals assigned to or situated in that sector; operate himself when deemed advisable; and in general carry out the orders of the Chief Surgeon, A. E. F., and chief consultant in surgery," thus clearly indicating that in professional authority he was responsible only to the chief consultant or the chief surgeon of the expeditionary force.

When we consider that the plan was an entirely new one, was not mentioned in the manual, was hastily considered in Washington, and transmitted to the A. E. F. without definite instructions, that no definite and uniform rules were established for its operation, that orders were not uniform, were frequently vague, and often greatly delayed, and that the line officers were generally left in complete ignorance of the plan and the status and authority of the consultants; it is a marvel that it succeeded as well as it did. In my opinion, its limited success was due to the vision and broad-minded attitude of General Ireland and his able assistants at the Chaumont Headquarters, to the honest efforts of the consultants themselves, and the hearty and intelligent coöperation of the majority of the regular officers.

I am thoroughly convinced that had the war lasted another six months, and had General Ireland's wise policy been continued in the A. E. F., after his promotion to the position of surgeon general, all obstacles would have been overcome, and the American system of professional control would have been declared an unqualified success.

In these few remarks I have attempted to answer briefly the two questions propounded in the opening paragraphs of this part of my address, but there is now another and more important question to be considered, and that is, what in the light of our past experience can be done now to insure better treatment for our wounded men in the event of another war, or to provide better care of our mobilized men if laws should be enacted authorizing universal military training.

In answer to this question permit me to say that, in my opinion, we can not do better than to adopt in principle the plan of dual control proposed by our surgeon general.

I sincerely believe, as stated above, that it is fundamentally sound, and the only plan that will insure to the wounded the highest degree of professional service.

That it was far from perfect in its operation during the late war, we will admit; but its imperfections and disadvantages were trivial in comparison to the advantages it presented, and easily could be remedied by more perfect organization. While doubtless it would be desirable to modify to some extent the regulations in force during the war, the plan should be essentially the same, and should embody the appointment of a chief consulting surgeon, a man of the broadest experience chosen from the civilian profession, possessing the highest qualities of surgical judgment and technical skill, who has had previous military experience, and who is also possessed of organizing ability. His headquarters should be in the office of the surgeon general, and to him all questions dealing with the actual surgical care of patients should be referred for his expert advice. That this chief consultant should have a number of deputies or assistant chief consultants, also men of conspicuous surgical ability and large experience. One of these to be assigned to headquarters of each army to coöperate with the administrative chief of the medical service. Under this deputy chief consultant there should be an adequate number of active consultants who could be assigned to corps or divisional areas in charge of the surgical work of the various hospital units, and who would be responsible through the army and chief consultant to the surgeon general for the carrying out of the most approved modern surgical methods in the treatment of the wounded men. This plan would obviously include a similar organization of the departments of internal medicine and sanitary service, with as many subdivisions of each as would be found to be necessary.

This, I beg you to bear in mind, is but the expression of my own personal view. I do not suggest it as a plan to be blindly followed or adopted without the fullest and freest discussion, in a conference composed of regular army officials and civilian practitioners who have had actual military experience; but I think that the time is now ripe for such a conference and interchange of views, and that now in time of peace some plan should be worked out to give to the American Army the best

professional service which it is possible to organize, which will insure to the sick and injured soldier the same degree of professional skill that he could receive in the best organized and equipped civil hospital in the country.

While such a plan would be an emergency measure, and while the consulting staffs would be members of the reserve corps, and not on duty in peace time, it should be organized now, down to the last detail, so that in the event of our country facing another military crisis, it would not be necessary to devise ways and means to meet the emergency in haste, during a period of stress, excitement, anxiety, and feverish activity.

I do not feel that we as an association of civilian surgeons should apologize for considering this problem, or should hesitate to offer to the military authorities our suggestions on a subject which so deeply concerns us. If in time of war we are to bear such a large proportion of the burden of responsibility, we are certainly entitled to a voice in the making of plans and regulations under which we are to assume it. It is for this reason that I have brought this matter to your attention. I have been so overwhelmingly impressed with the importance of this subject, that it seems to me it would be a gross neglect of duty if I were to have chosen for this address another and perhaps more conventional topic.

My message comes from the heart of one who has been an eye witness to the monstrous and cruel toll in mortality and wrecked lives which war inflicts upon the flower of the youth and promising manhood of a nation; and I urge upon you, as members of the most distinguished group of surgeons in America, to be prepared, if the opportunity is offered, to cooperate with our Government officials in proposing some enlightened plan which will raise the standard of our military medical service to a plane never before reached in the world's history.